STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255284	A. BUILDING **01 - 0101** B. WING _____	**11/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE NURSING CENTER	**3103 WISCONSIN AVENUE** **VICKSBURG, MS 39180**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on the observation and testing, the facility failed to provide half hour rating in the smoke barrier wall in accordance with NFPA 101 sections 19.3.7.3 and 8.5. This deficiency affected one (1) of four (4) smoke compartments, and 18 of 60 residents in facility. Findings Include: During activation and testing of fire alarm system on 11/9/22 at 10:50 AM, observation revealed the 100 Hall smoke barrier wall doors (near residents	K 372	K372 Subdivision of Building Spaces □ Smoke Barrier Facility failed to provide half hour rating in the smoke barrier wall in accordance with NFPA 101 sections 19.3.7.3 and 8.5. This deficiency affected one (1) of four (4) smoke compartments, and 18 of 60 residents in facility. Smoke barrier doors in-between rooms 103 and 104 on 100 hall did not close to a positive latching position to prevent the spread of smoke	11/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/28/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 372	Continued From page 1 ' rooms #103 and #104) did not close to a positive latching position to prevent the spread of smoke throughout the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 11/9/22.	K 372	throughout the facility. 1. Maintenance Director contacted Barnes Glass on 11/9/22 and the fire doors between 103 and 104 were adjusted and checked for positive latching positions following adjustments. (Exhibit # 11) 2. All fifty-three (53) residents currently residing in the facility of 60 have the potential to be affected by this deficient practice. 3. Administrator initiated in-service with Maintenance Director on 11/28/22 to check all fire door closure contact when checking fire system weekly to ensure compliance with smoke barrier doors. Exhibit 12 4. Maintenance Director will monitor all smoke barrier doors during fire system checks to ensure smoke doors are in a positive latching position beginning 11/28/22 for 2 x weekly x 2 weeks then 1 x weekly x 8 weeks. (Exhibit # 13) Maintenance Director will report any recurring problem to the monthly Quality Assessment and Improvement Committee. Administrator will take necessary corrective action such as: Individual in services, re-in-service, or contacting outside repair contractor and initiate Quality Assurance and Performance Improvement (QAPI) if warranted. QAPI Committee will make recommendations or changes as needed.	